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us today from the FCC we also have Dr. David Ahern, Dr. Chris Gibbons, Michele Ellison, Ben Bartolome, Katie Gorscak, Louis Peraertz, Karen Onyeije, and Dr. Kelly Murphy. At this time I'd like to remind you that today's conference is being recorded. If you would like to queue up for a comment at any point in time you can always do so by pressing * followed by 1. I'd now like to turn the call over to our moderators, Dr. David Ahern and Dr. Chris Gibbons.

DR. GIBBONS: Good afternoon, everyone. My name is Dr. Chris Gibbons and along with Dr. David Ahern, as you just heard, we will be moderating this session today. Thank you so very much for joining us.

The FCC and the Connect2HealthTaskforce are particularly delighted that you decided to join us today. We're really excited because it provides us an opportunity to hear from a group of very important stakeholders from which we don't normally hear. That is the primary objective of today, to hear from you.

So, as you will hear, this will proceed largely allowing you the opportunity to comment your thoughts and tell us your thoughts with minimal or no comment. As time permits we may towards the end have time for more open dialogue. If you're not able to say everything that you would like to say or let us know about please email us or contact us. To provide those comments our email is connect2health@fcc.gov. We will also be sending out an email to each of you who registered and are participating on the call today.

Once again, thank you. And with that I'll turn it over to my co-moderator, Dr. David Ahern to get us going.

DR. AHERN: Thank you, Chris. I will echo Chris' comments. We appreciate you taking the time out of your busy schedules to join us today for the Connect2Health FCC Listening Session for Healthcare Providers. We're very excited to have the opportunity for you to share your . experiences in the work that you're doing in your

organizations and in your communities.

As Chris mentioned, we're really wanting to hear from you. So, the format is to have each of you queue up to share your comments with us. We have about 25 or 26 participants on the call today which is great. That means that we will have to limit though the time that's available to each of you. So, I would ask you to be both concise and succinct with your comments, but as Chris mentioned we want to hear from you in addition in writing if there are other items you want to share with us.

With that, I think we can go ahead to see who has queued up first, if we have someone who has joined to speak. If not we'd ask you to do *1, I believe it is, to enter the queue because we're very interested in hearing your comments and your experiences. So, let's see if we can get that process going. You'll get into the queue in sequence and then have an opportunity to speak.

Who wants to be first? Hank, I know you're there.

OPERATOR: Our first comes from the line of Hank Fanberg of CHRISTUS Health. Your line is open.

MR. FANBERG: You beat me to it, David. First, thank you for the opportunity to provide some comments and thoughts for a very important program and need.

A little bit of background. CHRISTUS Health is a large Catholic Health System. We operate in six states and three Latin American countries -- but we won't worry about those for the time being -- corporate office is in Dallas, and we have hospitals throughout the state of Louisiana and Texas. Some of you may have a recollection that in about two weeks' time we will be celebrating the 12th anniversary of a little event called Hurricane Katrina. It was in the aftermath of Hurricane Katrina that I had my first interaction with the FCC and USAC because we had a number of hospitals that were directly in the path of Katrina and then Rita three weeks later. Both the FCC and USAC were instrumental in helping us

to restore our communications functions.

But beyond that, I think there are a couple of things. I've also had the opportunity to be the project coordinator for the FCC Rural Healthcare Pilot Program in Texas which actually started about 10 years ago, it's officially over. I think that provided me some additional insight into the importance of broadband because it really is the forgotten foundation of everything that we want to do. Healthcare is rapidly adopting different platforms, new platforms in terms of delivery, telehealth is becoming more and more prevalent even though there may be some reimbursement challenges still to deliver.

And that change is happening very, very quickly, and the rate of change, and how we are providing care, and the tools that we are using to provide care is happening at a faster rate than the regulatory bodies are able to do as well.

So, I have a couple of thoughts on a couple of ideas. Number one, we know that from our own experience at CHRISTUS we have geographies

where there may not be any broadband available and sometimes that includes cellular in some of our rural and frontier areas in Texas. Number two, actually within your heavily populated cities there are also pockets where access is limited which is probably more of an economic reason than availability. Number three, the needs for speed, broadband speed, circuit speed, has increased as we continue to leverage telehealth to provide initial consultations in emergency departments in the rural facilities where you may be sending images -- not just data but images and video -- and T1 lines are totally insufficient for that but the infrastructure to do more than that may be lacking. Number four, we are sending patients home and we are monitoring them post-discharge. This was brought about in part by the need to keep people out of the hospital for the admission rate with CMS and remote monitoring of this type is something which has not really been -- anything into the home has not been something that really has been addressed by the FCC through the

Healthcare Connect Program.

So, I think it would be a wonderful idea if the FCC could take on some innovation activities and begin to seed some new ways, some innovative ways, of leveraging broadband so we are able to connect provider-to-provider, provider-to-patient and really have an impact by being able to deliver care to where people are. We're becoming a mobile society and we need to follow that. I'll take a breath and stop now.

DR. AHERN: Thank you so much. That was really very helpful to us and we appreciate your experiences. I would just take this moment to remind our participants that the questions that you were sent on that two-page document, the Broadband Health Technology Public Notice, any of those questions we're interested in feedback and your experiences, so that's a reference for you.

Again, I want to remind the participants that in order to be on the queue to share your experiences you do need to press *1 and we're now beginning to see that which is great. So, let me

turn it over to Justin. If you would ask the next participant to identify themselves.

OPERATOR: Absolutely. Our next participant is Jon Zasada of APCA. Your line is open.

MR. ZASADA: Good morning. My name is Jon Zasada, I am the Policy Director for the Alaska Primary Care Association. We support the operations and development of Alaska's federally qualified health centers. My tact for responding to this was to have a couple of bullet points for each of the questions.

A little bit about us. Federally qualified health centers in Alaska, there are 25 organizations, 169 sites. Of those 169 sites, 156 of them received USAC RHC broadband subsidies to the tune of a requested $88 million in 2016. It is one of the largest expenses for the health centers that we serve. Alaska's health centers are spread throughout the state of Alaska in communities large and small, tribal and non-tribal.

The primary challenges for providing rural and frontier care in Alaska include reliable workforce, small communities, distance of regional health facilities, and a range of others. The use of broadband technology in Alaska's rural health centers includes telehealth visits between small health centers or community-based sites including schools and other facilities, cloud-based electronic health records and prescription systems, use of contracted imaging for sonograms, x-rays, and other services related. We have one health center that provides a virtual emergency room with a dedicated connection to the largest regional hospital in Alaska, based in Anchorage at a distance of 1,300 miles between the health center and the hospital. There is also limited use of in-home monitoring.

In terms of the future uses that you requested, the state of Alaska did engage in an omnibus Medicaid redesign in 2016 that has resulted in a relaxing and expansion of licensure and other issues to allow an expansion of billable

telehealth services, especially behavioral. I think looking into the future also additional opportunities for patients to do self-monitoring and reporting for care coordination and case management with distant providers.

Then, finally, one other future use would be the new VA telehealth initiative that is scheduled to rollout in Alaska later this year. And I personally have some worries that in its rollout many of the potential users might not have the speed of broadband adequacy on their personal devices to take full advantage of that, and I do think it would be a shame if expectations there are not managed.

In terms of health providers' technical requirements and needs, right now, I'll be real honest, I think we're very happy with what we can get and are always trying to secure the minimum FCC adequate access of 10 upload 3 download. I will be submitting additional information following this conference with comments from the IT staffs in a number of our health centers.

The non-technical issues related to broadband adoption, I would say really the primary impediment at this point in time is a looming sense of financial risk if the subsidies of the RHC Program are not reliable in the future. I think you could see small providers looking twice at the dedicated broadband that they're currently using if they think that they're going to have to pay an increased amount of that cost in the future.

All that being said, many health centers in Alaska are fully engaged, have built up their systems based on reliable, dedicated broadband with speeds as fast as they can get in the communities where they are and with the past knowledge that the subsidies necessary have been available.

In terms of finally increasing public awareness about the availability of benefits of broadband as they relate to health in rural areas, at least in the state of Alaska I think it would be important for the FCC to help bridge the divide

of knowledge between the E-Rate Program and the Rural Health Program. When we speak with Alaska legislators they don't necessarily see the connection between the two programs and how they operate and I think going forward that could be valuable.

And I also think that increased outreach between the FCC and municipalities in the state government could be very important. I know that during our last legislative session a group of rural health broadband advocates are working on getting a resolution of support for modernization of the RHC Program, and again, additional outreach from the FCC would be valuable in that process. That concludes my comments. We very much appreciate these listening sessions.

DR. AHERN: Thank you, Jon. That was fabulous. We really appreciate you providing responses to all of the questions and obviously very thoughtfully putting the time into that. We particularly liked that you're balancing sort of the challenges and the barriers that you've

experienced but also some of the bright spots in Alaska, and I think that's important for us to hear and to document.

Again, I would remind our participants that this is an opportunity for you to communicate to us what are some of the important areas that you want us to highlight, what the FCC can do to address some of the challenges that you're experiencing in your particular areas of the country. In order to do that we need to have you do *1 and please tell us your story. With that, I will ask Justin if you would introduce the next speaker.

OPERATOR: Absolutely. Next we will go to the line of Jonathan Bailey of Mission Health. Your line is open.

MR. BAILEY: Good afternoon, and thank you for allowing us to have this opportunity. It's a great opportunity to not only hear what's going on but to share some thoughts. I appreciate your time.

My name is Jonathan Bailey, I serve as

the Chief Program Development Officer for Mission Health. We are a seven hospital health system located in western North Carolina and we are headquartered out of Asheville, North Carolina. And we have the unique opportunity of really providing care as the region's only tertiary referral center to both very rural areas that are geographically dispersed as well as metropolitan areas that suffer some areas of lower-income impoverished areas that don't always have the financial means to be able to afford access to broadband technologies.

We've taken a very, very aggressive approach into the work of expanding virtual care and telehealth offerings throughout western North Carolina. As we look at the future, as we think about healthcare delivery, our view is that we need to accelerate this and to really help leverage the use of broadband and the assistance of the FCC to continue to help us be able to reach these rural areas, particularly in counties that are anywhere between 0 to 20 percent of coverages

for download and upload speeds and to be able to help leverage this health technology so that we can really take powerful impact to lowering our overall cost of the healthcare delivery system. We're currently offering virtual care services in 20 different clinical specialties and are touching about 10,000 patients per year. And through audio/video connectivity, we do a lot in behavioral health and some of the higher acute areas, but we know the opportunity out there to touch and impact lives is significantly greater. Just as was talked to by I think Hank, relative to our ability to connect with patients in different locations there are some areas in particular that we believe the FCC could be helpful to enable further reach, and that is in areas such as schools. The ability to reach different school locations and help to ensure the broadband access and the connectivities are there in all the different schools is essential to ensure we can connect with those school-based telemedicine programs.

And also really the home. I think in the commentary, in the initial handout, was this "hospital in the home." We believe that's a huge opportunity going forward where patients in the future will be admitted to their home, but that means the home has to have the right kind of connectivity so that we can have the monitoring and the ability to get into that home, to be able to know where the patient is in their clinical recovery basis and that the interventions we're taking are actually making an impact. That's probably I think one of the biggest areas of opportunity where we are struggling.

I think number three on there was non-technical issues in promoting broadband adoption. I think there are opportunities for crossover amongst our federal agencies to better enable and remove the barriers that are in place today, in particular the geographic barriers that are in place today through CMS that create a disincentive from a financial reimbursement standpoint when we're trying to connect with

patients in these urban areas. While they're urban in nature that doesn't take away the disparities that many of these individuals that live in those areas experience and their struggle to be able to pay for broadband and to be able to access healthcare services.

I think just further awareness in expanding the information around how critical the nature is, both to the public and to our various legislators and policymakers is of critical importance. So, with that I'll stop, and, again, thank you so much for this opportunity.

DR. AHERN: That's wonderful. Thank you, Jonathan. Just as a follow-up question, if I may for you, particularly around the hospital in the home concept, could you explain a little further about that for our participants who may not be as familiar with that concept?

MR. BAILEY: Sure. So, this has been tested out in the EU as well as it's very popular in Australia and it actually made its way to the U.S. Johns Hopkins has done quite a bit in this

area. But in essence the concept is instead when a patient may show up to the emergency department or a physician would have otherwise admitted a patient to the hospital for some sort of treatment or observation, enabling that that patient -- let's just take a patient that comes through our emergency department, that they would instead be admitted to their home, transferred to the home, and outfitted with the various technological peripherals, the monitoring equipment to be monitored by a central agency, and have frequent nursing visits and they come and check on a patient firsthand, but the physicians and other care providers would be able to remotely connect in with the patient to be able to see what's going on with their physiological monitoring and/or be able to talk with the patient directly using two-way audio/video, and then be able to make interventions and decisions based on that. It will help alleviate the need for the expensive hospital beds that we have so vastly across the country.

DR. AHERN: Fantastic. Thank you, Jonathan, really appreciate you explaining further your experience with that concept. If there are other participants when their opportunity to comment comes up they want to talk further about that, that's great. Let me ask Justin if he would again go to the next participant in the queue.

OPERATOR: Certainly. We have Beth Hahn of Flambeau Hospital. Your line is open.

MS. HAHN: Hi. I am part of a community group that is currently participating in a pilot project through the University of Wisconsin extension broadband expansion. Our pilot project is connected aging communities. We are located in a very rural area of northern Wisconsin. We are a community group comprised of community members from hospital and clinic providers, health and human services including the aging unit providers and our local broadband provider.

What we are looking at is ways to get seniors connected. One of the focuses of our group, we have several different focuses but the

main one that we're looking at is telehealth, telemonitoring, how can we get seniors connected in northern Wisconsin to their healthcare providers, that might be home health providers trying to monitor patients following a hospital stay or the hospital trying to prevent a hospital readmission has been addressed previously.

Connectivity in our area is definitely an issue, reliability and speed from patients' homes and even sometimes with the healthcare providers travelling into the field, and how do we get seniors to want to be connected for health issues or just for social media. We're trying to figure out different ways to get seniors to feel that this would be a valuable service for them to have in their home.

Our broadband provider has been trying to expand availability in our local counties by providing more fiber optics and laying more fiber optics but that's always a cost to that provider. So, looking at ways that broadband can be adapted, specifically with my focus on the healthcare

settings, and how do we get people connected, and then is there funding availability once we talk them into being connected then how do we get them to be able to utilize the services that we're trying to provide to them.

So, it's a totally voluntary community group that's trying to figure out ways to utilize this within our organizations and for the good of the community. I'm hoping that some of the information that I'll receive today on the listening session is some insight into additional funding opportunities that we can continue to do this group after our two-year pilot project is over which is minimal funding. But just trying to get out there and explore opportunities for our seniors and people within our healthcare community as a whole.

So, I appreciate the listening session and I've already learned a lot from what I've heard, so very interesting. Thank you.

DR. AHERN: Thank you, Beth. Actually, one brief follow-up question, if I may. Of the

monitors that you're using to connect seniors in your project do you know if they're wireless? What are the sort of technical communication aspects of it, do you know?

MS. HAHN: What we're looking at right now and what we're utilizing is they are not wireless, they are wired just because of the connectivity within patients' homes. We're just doing it by an internet connection. Right now we're also looking at patients being able to get a smartphone or utilize a smartphone or some type of an iPad system if they have availability to wireless within their homes. But right now we're just trying to do it with fixed.

DR. AHERN: Thank you, Beth. Appreciate that. Before we move on, we've actually had a number of additional participants join the call since we began. Justin, I wonder if you could introduce those additional participants before we proceed with the queue?

OPERATOR: Certainly. We have been joined by Ken Stigen of RCMH, Seva Kumar of WSHA,

Jonathan Bailey of Mission Health, and Craig Jacobson of Hobbs Straus & Dean.

DR. AHERN: Great, thank you, Justin. Again, for those that have just joined this is an opportunity for your as participants to share your experiences with the Connect2Health FCC Taskforce. The questions that were sent to you, the two-page document, are the questions that we are particularly interested in hearing your experiences about, but any areas that you want to focus on in telling our story to us would be greatly appreciated. In order to do that we need to have you press *1 on your phone so that you can get into the queue. We're trying to see if we can build this queue up to make sure that we have as many participants joining in on the conversation today.

I know this is a little bit different than perhaps other calls that you've had where it's been more of a discussion and we will have an opportunity to do that before we conclude our session today. But please do *1 and you'll be put

into the queue for you to be able to share your comments.

Justin, I do think we have another participant ready to contribute.

OPERATOR: Absolutely. Next we go to the line of Michael Iaquinta, of iSelect MD. Your line is open.

MR. IAQUINTA: Thank you. I'd like to thank the FCC for allowing us this forum. This is really great and obviously well-attended.

Once again, my name is Michael Iaquinta, I'm with iSelect MD. We focus on two areas. The first is delivering telemedicine services either through voice or video utilizing broadband technology to folks in rural areas for either primary care and one of the new things that we've been developing over the last six to eight months is Obnet which is recovery and treatment for the opioid challenges we have. We do that through outpatient-based medication assisted treatment.

So, the challenges that we see, first of all the uncertainty whether the Affordable Care

Act and obviously repeal and replace, high deductible programs that impact lower-income folks, broadband users in rural areas, and also the looming and physician shortages that we're seeing. So, what I wanted to share was, once again, some of the things that we're doing and how the FCC and healthcare providers that focus on broadband delivery methods can help reduce cost and improve access to areas of care.

So, right now, our company has five different wireless carriers that we deliver mobile health services to, and we see a significant decrease in cost directly associated with procedures but also more importantly pharmaceutical costs. Because we are what I refer to as symptom and patient specific, when you go into a setting typically you might be prescribed multiple different medications even though you may have gone in there for an ear infection. So, we're seeing significant reduction in pharmaceutical costs to insurance companies, to patients, subscribers.

On the opioid treatment and recovery what we're seeing is is in many cases there are two things that really stick out. First of all, in seeking treatment a lot of times with how this has exploded is there's a three- to six-month wait before somebody that recognizes they have a problem can then get in to be treated. Through bidirectional video we can triage those broadband utilizers face-to-face and in real- time, and in a lot cases get them the medications they need to augment the withdrawal they may be experiencing. We treated a nurse the other day that came forward and was able to really get her on the road to treatment and recovery.

The second thing is we see that embarrassment aspect where if somebody wants to show up at a physical location they're there with other people in the community. So, we've really created an opportunity for people to have the confidentiality, privacy, and the access to treatment on the opioid issues.

The other thing is that a byproduct of

this, what we're seeing is a lot of the pharmaceutical players scale back on how freely opioids are getting to the broadband user. What we've done here is we've seen a transition from opioids to heroin and the new drug is now fentanyl, so when the opioids dry up we see them migrate to that.

I think there's a number of ways that the FCC through pilot programs and funding can help improve access to care, especially in the rural areas for those two things: Primary care and for opioid addiction treatment and recovery.

DR. AHERN: Thank you, Michael. Dr. Gibbons has a follow-up question.

DR. GIBBONS: Well, it actually wasn't a follow-up question. I think these have been fantastic comments so I just wanted to reiterate my thanks for you offering them. I know we also have some participants who may not work for provider organizations, hospitals, health systems directly but they work in the area supporting, doing research, doing other things. We'd also

love to hear from the perspectives of those organizations, philanthropies, think tanks and others who are on the call telling us what they're doing, what they're seeing, what they're learning as well. So, I just wanted to reiterate that point. Thanks so much.

DR. AHERN: Thank you, Chris. On that note, again, I would mention that in order to share your comments we need you to press *1 on your phone and that will put you in the queue. Right now there's a short list so you really don't have to wait long to be able to share your comments. We really would appreciate it if you would do *1. And, again, it can be as long or as short now as you choose, but we're very interested in hearing from you on the call today.

Justin, if you would ask the next person to comment.

OPERATOR: Certainly. Our next comment comes from the line of Verné Boerner of Alaska Native Health Board.

MS. BOERNER: Hello, can you hear me?

OPERATOR: Yes.

MS. BOERNER: Oh, great. Hi this is Verné Boerner, President and CEO for the Alaska Native Health Board. I want to thank the FCC for the opportunity to participate in these listening sessions. Broadband is quite critical to the Alaska tribal health system overall.

The Alaska Native Health Board is an advocacy organization supporting the Alaska tribal health system and supports 229 tribes and over 158,000 American Indians and Alaskan natives and thousands more. The Alaskan tribal health system is a critical part of the Alaska public health system, often the tribal health facilities are the only access to care in those rural and frontier communities.

Alaska has over 660,000 square miles and a very sparse road system. In many cases we can only reach the communities by air, water, or on snow machine in the winter. So, having access to telehealth has been a critical part of our care and one that has been developed early on, and

broadband has become an integral part of that system of care.

So, telemedicine has allowed our members to dramatically improve access to care, accelerate diagnosis and treatment, avoid unnecessary medevacs which cost tens of thousands of dollars, and they expand local treatment options as well. Alaska has been quite innovative in developing (inaudible), in partnership, and with the utilization of the Rural Healthcare Program, has been able to also greatly improve medication management, reduce hospital readmittance, increase patient safety, and bring a sense of security for those who manage patients' care. Those are just a few examples of how technology has been leveraged in the state.

I also wanted to take a brief moment to endorse and agree with the comments that were already provided by Jon Zasada with the Alaska Primary Care Association. He did a great job in identifying some of the specific uses with x-rays and cloud-based storage and virtual emergency

room. Those are just great examples here.

One of the challenges that we have seen of recent too in thinking about the sort of non-technical issues is the recent proration of the Rural Healthcare Program. That has acted to destabilize some of our efforts because the broadband is not just part of telehealth, it goes to the total infrastructure of how we provide services. It helps us meet reporting requirements and compliance issues that affect our delivery of care but also our ability to bill and feasibility of our programs overall. Similar to the community health centers, the Indian Health Service just funded facilities are not able to raise our service rates to compensate for any increase in cost due to that proration. So, finding a long-term solution is something that is critical to help support the advances that have been made for providing care in rural and frontier communities overall.

As far as increasing public awareness, the FCC doesn't need me to tell it that in many

rural areas in Alaska many of the community members and communities themselves lack access to high-speed broadband, upwards of 80 percent and in some cases more. Having that general lack of access to broadband is a barrier to help increase the public awareness of the benefits that it brings. So, thinking about different ways that we can utilize the infrastructures that are already there and maybe underutilized to help increase that access generally is one way to help raise awareness.

And then as far as requests for research and case studies, Alaska has 229 tribes and 660,000 square miles to offer many, many opportunities for research and case studies, and we would definitely like to be a part of that. Thank you.

DR. AHERN: Thank you, Verné. That was very helpful and I appreciate your comments.

Are there any other participants who would like to make any introductory comments where we can have the line available to them? We can

take a moment to see if anybody else wants to press *1. If not, we can open all of the lines for general discussion and we can begin with a few questions. But this is, again, an opportunity for any of the participants to tell us a bit about your experience in the area you're in with your organization. So, one last request for *1 for any of our participants.

Thank you. Justin, if you would go ahead and have our participant be introduced.

OPERATOR: Certainly, thank you. We have Carey Officer with Nemours Children's. Your line is open.

MS. OFFICER: Thank you so much for the opportunity to speak and tell you a little bit about what we're doing.

So, we come from a little bit different perspective from the fact that Nemours is actually an organization fully dedicated to pediatrics. We have two free-standing children's health systems, one hospital in Orlando, Florida, and one in Wilmington, Delaware, and then also service many